Substance Abuse Services Division
ASAIS Conference Call
February 17, 2006

Minutes

- On February 17, 2006, the second Substance Abuse Services Division's Alabama Substance Abuse Information System (ASAIS) conference call was held. The call began at 10 am and hosted approximately twenty-two provider organizations, most with multiple staff participating.

- Agenda Item # 1 - Introductions: Ms. Harkless welcomed and thanked the providers for joining the 2nd ASAIS conference call. Ms. Harkless asked providers to introduce themselves. The following organizations were identified. We apologize if any were omitted.

  Alcohol and Drug Abuse Treatment Center
  The Bridge, Inc.
  Chilton Shelby MHC
  Birmingham Fellowship House
  Mobile Mental Health Center
  JBS Mental Health Authority
  Pearson Hall
  Mountain Lakes MHC
  East Central Alabama MHC
  Dauphin Way Lodge
  CED Mental Health Center
  Drug Education Council
  Cahaba Mental Health Center
  Riverbend MHC
  Aletheia House
  Anniston Fellowship House
  Franklin Health Care Systems
  Quest Recovery Center
  Calhoun Cleburne MHC
  Phoenix House, Inc.
  Huntsville Madison MHC
  Northwest AL MHC

- Staff participation included:

  Ms. Sarah Harkless
  Ms. Lynn Frost
  Mr. Kris Vilamaa
  Ms. Kathy Seifried

Mr. Brandon Folks
Ms. Crystal Jackson

Mr. Kris Vilamaa joins us from ADECA as the Project Manager for ASAIS and the Director of Information Services for the SASD. Ms. Harkless is delighted to have Mr. Vilamaa on Board. Ms. Harkless has been the Acting Director for the ASAIS Project and Mr. Vilamaa will assume the duties for the project and will soon be the moderator of the conference calls.

- Agenda Item # 2 – ASAIS Update: Progress is being made and the business analysis documents are still being reviewed. It is taking quite some time to make sure the division's business process is being thoroughly documented. Every step has to be listed in that process. It is very tedious. We hope to stay with the timeline that is in the packet. Business functions are the same as described on the last conference call and a copy is made available in your packet. Ms. Harkless asked if there were any questions relevant to the information that was sent in regard to the previous conference call or anything relevant to the ASAIS update.

  Mr. Kris Vilamaa offered an update on the website. This is another way of communicating with the providers. We are working on a website that should go live hopefully in the next week. This will offer an opportunity for providers to access information on the ASAIS project, the agendas, the minutes and other relevant information.

- Agenda Item # 3 – Services Descriptions Review:

  Questions from the provider participants:

  1) Is there a definition for the data field for the client identifier?

     No, we hope to have that information to you by the end of February.

  Ms. Harkless sent a listing of the proposed services that are being planned to implement under the levels of care relevant to the ASAM criteria. The plan is to go with ASAM and each service category in the level of care would be recognized. We will not fund all the levels of care but we will recognize that people will be accessed as needing a level of care that we do not fund. We still need to know that. You have an excel spread sheet of what we cover. There is a lot more on this list than we currently have.

  2) There are different limits for Medicaid and ASAIS. It is understood there will be an attempt to have the limits from Medicaid and ASAIS contract be the same.

     That is the goal. We do not know if it can be achieved because we do not know how much we can change on the Medicaid side. But that is the goal to have both the same where it is beneficial.

3) Something was sent out from the SASD that recognized there are homeless people or low income people that need residential support in order to access these services. How do you envision services for people who need housing or other supportive services in order to access the clinical services?

   The service array that we have addresses that because we have several levels of residential treatment. We could not recognize just housing alone as treatment so we are going with the clinically managed low intensity residential services. There are listed services that can be provided to people who meet the criteria you have described. We are recognizing, in the proposed levels of care, what we call now bed board and protection and then you can add services as you need them based upon the services listed. We have tried to take into consideration that all clients need different services. All programs do not have to be the same. Definitions for each level of care as well as each service will be provided. Some people could get low intensity residential support as well as employment support at the same time. Other people may need more therapy than that. We want to have the levels of care clearly defined but what happens in those levels of care may be different depending upon the program and the needs of the community. We want to really put in flexibility that we do not have now.

4) Explain the differences between the three different accommodations.

   It will be dependent upon the program. There will be surveys sent out for providers to complete and technical assistance will be provided by the Division to know what is being done at the programs now and how it fits into the services now. We know some people now have what would fall under the category low intensive care but it is more like the old halfway houses. The chemical dependency would be more like crisis residential. The supervision would probably be a low intensity residential service with employment support. Clients would actually go through several levels in the same program. This is why the SASD would like to work with each program individually to see what is happening in your community, what are you trying to accomplish with your program now and try to make these levels of care work for your clientele.

5) Which service would be equivalent with the bed/board and protection?

   There are three categories: the behavioral health accommodation halfway house, the chemical dependency and supervised living.

6) Is there a length of stay determined yet? How many days will a client will be able to stay in one of those categories. Is that based on the need or is there going to be a cap on this?

   We do not know for sure if we will cap services. It is our desire not to.

Ms. Harkless wants everyone to look over this because this is the first draft and something may have been left out that is important. This is only a draft and as soon as the definition for services and the level of care are defined this will be made available as well.

- Agenda Item # 4 – Staffing Requirements: This has been a source of a lot of concern in regard to whether we are requiring all masters level counselors now and whether programs will have to let current employees go that are currently providing services. This concern arose when a statement was made in regard to Medicaid services and the block grant services being on the same level. You should not in any way have to fire anyone you have now. We are not requiring all masters level therapists. The Medicaid staffing standards and the substance abuse staffing standards are the same. We intend to keep them across the board the same. I know a big question came up in regard to bachelor level counselors. You can hire a bachelor level counselor right out of college and that person can be approved by Medicaid, according to the standards we have now. What would be required on both sides, Medicaid and SASD, right now is that this person receives two years of supervised experience, four hours a month and that does not mean they have to come in with the two years experience. They have to have it. You hire them and you give them the supervision.

7) This has never been the understanding of the providers.

   Ms. Harkless understands the confusion, but the standards are the same for both Medicaid and SASD.

8) Was this explained by someone at Medicaid?

   We send those requirements to Medicaid. This came from our office, from our standards. If you look at the Medicaid standards and the SASD certification standards the wording is the same.

9) There is one difference. The Department of Mental Health standards specifies two years of experience and the Medicaid standards specifies two years of substance abuse experience. What we are discussing is a bachelor level counselor. In the past what we have sent for Medicaid approval for a clinician if that clinician does not already have two years of substance abuse experience as documented on their resume then that person has not been approved and has not been sent to Medicaid for approval.

   If that has happened in the past it will not happen again.

10) So what is being said is that we can hire a bachelor level person out of school without any experience and give them the supervision for two years and during those two years they will be approved.

    To do counseling and treatment planning at Medicaid. Whatever is in our substance abuse standards is in the Medicaid standards.

11) What about a person that is a certified counselor. Will they be recognized?

The Medicaid standards for treatment planning and counseling covers a person who meets the assessment requirements. A person with a masters degree in a clinical area with a clinical practicum, a person with a masters degree without a clinical practicum and there are some additional requirements for that person. A bachelor's degree and a person certified as a qualified substance abuse professional by an independent board established for the purpose of providing an evidenced based voluntary credentialing process. It is the same wording in the certification manual and the Medicaid manual and this will not change.

12) Could Medicaid interpretation be different than the SASD in regard to the bachelor level counselor receiving two years supervision?

Medicaid does not interpret this, we do. We approve the providers.

13) Medicaid performs audits and if the Medicaid auditor needs to see the two years experience and the person does not have it we have to pay them back all those claims, who will be responsible for that.

In our contract with Medicaid it says we are the one that approves the providers. If we need to change the wording in the Medicaid manual to make it clearer we can. I do not think that problem has come up because apparently no one has gotten a Medicaid bachelor level person approved. We approve providers. I do not see how Medicaid would have a problem with that when we have approved the provider. We send Medicaid the standards that we want in their provider manual for qualifications. An auditor should not have problems with that.

Ms. Harkless will make all clear and it will be made the same across the board. The Medicaid standards for staff have come from the SASD standards. It is in the Medicaid Administrative Code now as presented.

14) Will you put clarification of this in writing?

It will be in the certification manual as well as the Medicaid manual. It is clear in the certification standards now in terms of a bachelor degree. It references sections 3109 which talks about the supervision requirements.

15) Does the two years supervision experience gained while employed for the bachelors degree also apply for the masters degree in terms of the assessment or does that experience have to be prior to the assessment?

In the standards it says at least two years of clinical experience. This would be in addition to the masters degree not attained concurrently. The word supervised is in the substance abuse standards manual and in the Medicaid manual and there is no supervised clinical experience requirement in either manual for assessment.

We really want to clear this up. We will get out written clarification to you. In terms of the Medicaid manual update that probably will not happen until we update our services. We will get clarification and we will clarify what is already written in Medicaid and substance abuse.

16) The bachelor level person under the Medicaid standard number 105.1 and 105.2 reads a person with a bachelor degree or a RN and two years of supervised substance abuse clinical experience. But under 3109 the substance abuse standard clearly reads that does not possess a master's degree and has less than two years experience that that's where you plug in that 4 hours a month. The 3109 is very clear but the 105.1 and 105.2 seems to read that Medicaid people should already have the two years experience. If the Medicaid standards could be more in line with the 3109 substance abuse standards then it would be more clearly defined.

    Our standards read a bachelor degree and two years supervised clinical experience and we do not have the substance clinical experience and I do not know why we could not reference something in regard to that. The "supervised" is the key and we will have that piece in the Medicaid manual understood.

- Agenda Item # 5 – Timeline:

This is a basically what is going on with us. We are very serious about improving and enhancing our communications with our providers. We want to do everything we can to keep the doors of communication open. Testing will begin in May at the latest. Policies and Procedures and an operating manual will be developed. Training will be taking place as needed. Our aim to go live is still October 1st.

17) Is there a possibility of getting case management as a Medicaid reimbursement service?

    No. There has been a lot of abuse regarding case management and they are not entertaining adding any new services. We are creatively using what is there now.

18) Where are we in the revision of the assessment?

    That is going to be part of the policies and procedures development. The go live will be October 1st for the new assessment.

19) Is the intention to use the provider's unique Medicaid number to do Medicaid billing?

    Yes.

20) Will there be any delay in the providers getting their EOP's?

    No, we do not think so.

There were a couple of questions that were sent in and if there are any questions we will be happy to entertain them.

20) What will we do when the assessment indicates that a certain level of care is needed but that service is not available in that region? In the past the system has not always recognized that poor people do not have the access to transportation needed to get to the service. This can include a recommendation for IOP when the client does not have a car or a recommendation to go to a residential program in another city without providing a bus ticket, etc. to get there.

We know we do not have all the levels of care where they need to be. We are hoping for a system that will be developed that will include different levels of care and different services when things other than residential or IOP can be offered. We have recognized in this system outpatient care and it is a goal to have assessments and a type of brief intervention in every county in this state. Hopefully transportation will be included in a regular service and in addition to a Medicaid reimbursed service. Maybe that will help when a client does not have a service in their region.

21) How will the system track people in interim level of care?

People in interim level of care will not drop off the waiting list. They will remain on the waiting list until they are placed in the level of care to which they were assessed or they want to come off of the waiting list.

22) Do you know what percentage of funds will go toward residential treatment, what percentage for outpatient treatment, etc?

No, we will not be able to make projections until we visit each program and go over the service descriptions. We have not made any projections.

23) Will you develop workflows on the timelines during the site visits?

Yes.

24) The length of time a client has to wait for an assessment is directly related to the severity of a client that will be assessed. If your client has to wait one day you will assess sicker clients than when they have to wait a week to get an assessment. The sicker client's will go back using instead of waiting. On the other hand, programs that have done a lot of assessments in relationship to their total services have in the past been criticized. If you are using assessment data to establish need it is critical that you allocate enough resources to do assessments so that everyone gets an initial assessment in a timely manner.

That is a very good point and one we agree. That is one of our goals. Right now assessments are only covered under IOP services. That is not the case anymore according to the service grid. It is considered an outpatient service and really can be done at any level of care. That is one way to make assessments more available and

we hope that we can get assessment services available in every county and at least a brief intervention service in every county. This is a very critical piece.

25) You did not see Medicaid expanding but you expect to get at least a brief intervention service in every county. Do you expect for those services to come out of contract dollars?

Right now Medicaid pays for assessments and they pay for individual counseling. It could be an individual counseling session or a family session or it could even be a group setting. Those things are covered under Medicaid.

We are hoping as we are able to get data and identify needs more we will be building a case for going to the Legislature and asking for additional funds for substance abuse.

26) On the individual counseling when all this goes into effect will Medicaid provide that funding for individuals that is done in a residential setting.

We cannot change any of that. The service descriptions that are written in Medicaid now pretty much indicate that the settings are only limited if it is a hospital.

27) Will there only be one day for residential detox?

Right now you are limited to four days. It is not our intention to put limits on any service. There will be some ranges for IOP in terms of number of hours per week. We want to stay far from that as much as possible because that is not individualized care and our overall goal is to help people get what they need.

28) On Medicaid limitations right now there is a provision where you do an EPSD on a child it will remove those Medicaid limitations. Do you perceive that removing limits for ASAIS?

I do not know right now. You will have to brief me and we will have to get up to date on that.

29) How many employees are needed for the implementation of ASAIS?

Actually, in terms of ASAIS we have only hired two additional employees. We have needed an Information Services Director and Mr. Vilamaa is also assuming the Project Director's duties as part of that job. We have hired two enrollment specialists. Those are the only employees that are directly related to the implementation of ASAIS. We have hired a co-occurring coordinator. We will hire a Medicaid coordinator and a Child and Adolescent coordinator.

30) The statement you made about the number of hours per week for IOP; are there a number of hours per the standards that needs to be for IOP?

ASAM recognizes an average of nine hours per week for IOP. We will change the standards from a monthly to a weekly average. It is whatever ASAM recommends.

31) If we have a Medicaid client in residential treatment and that client needs a Mental Illness service we are blocked out from billing that service. Will this eliminate those kinds of barriers? Will a substance abuse client in a residential program receive a mental illness service and an agency be able to bill for it.

This is happening now. We are learning a lot as we talk through the services and identify barriers. As long as it is not excluded in the Medicaid manual it is happening now. What we are proposing to do is come up with the modifiers on the service descriptions. We are going to recognize and come up with some rates for co-occurring services.

32) What kind of work has been done on the outcome component of the ASAIS system?

Our responsibilities in terms of outcome have been dictated by SAMHSA. We have sent two proposals to SAMHSA to describe how we will collect the outcomes. On the treatment side SAMHSA has placed the collection of the outcomes in the treatment episode data information. They have modified the TEDS data and collection of the measures will be completed during the intake process and again at discharge. On the prevention side we will establish a state epidemiological workgroup in order to collect the prevention national outcome measures. Some will be collected from the prevention activity sheet but some we will have to almost do research work in order to collect. We will have to have an epidemiologist to come in and create a state profile and submit to SAMSA.

33) Have the questions been identified that will be in the TEDS indicators?

You should have that by the first week in March.

34) Will the department expect us to collect information now or when ASAIS rolls out?

Once ASAIS rolls out.

35) The contract amendments for prevention have not been received. When do you expect these will be sent?

The contract amendments are on Mr. Hunt's desk for his signature. Upon his signature they will go to the contracts office for their review and mailed to the prevention providers.

No further questions. The call ended at 11 am.